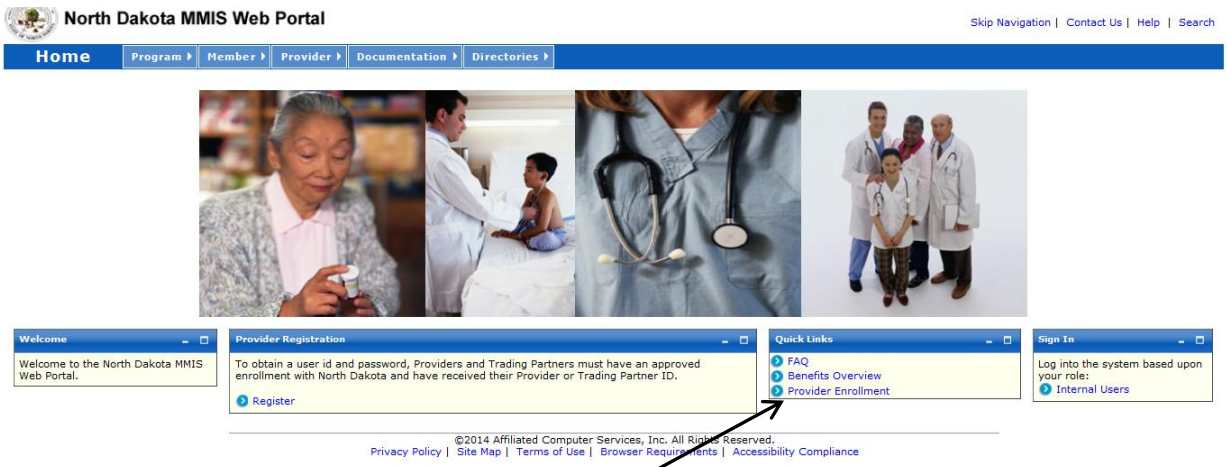
QSP AGENCY PROVIDER APPLICATION INSTRUCTIONS

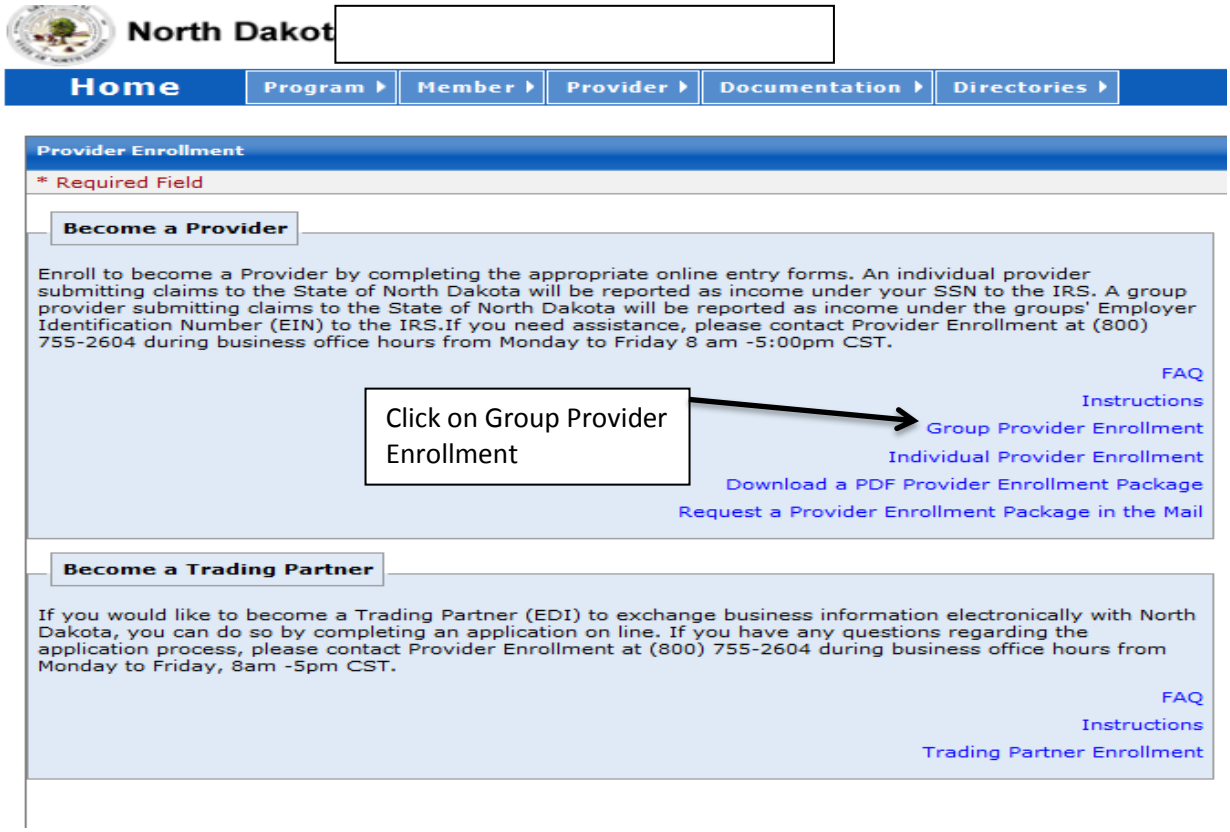
STEP 1: Go to the website link listed below.
https://mmis.nd.gov/portals/wps/portal/EnterpriseHome

You should see this screen:

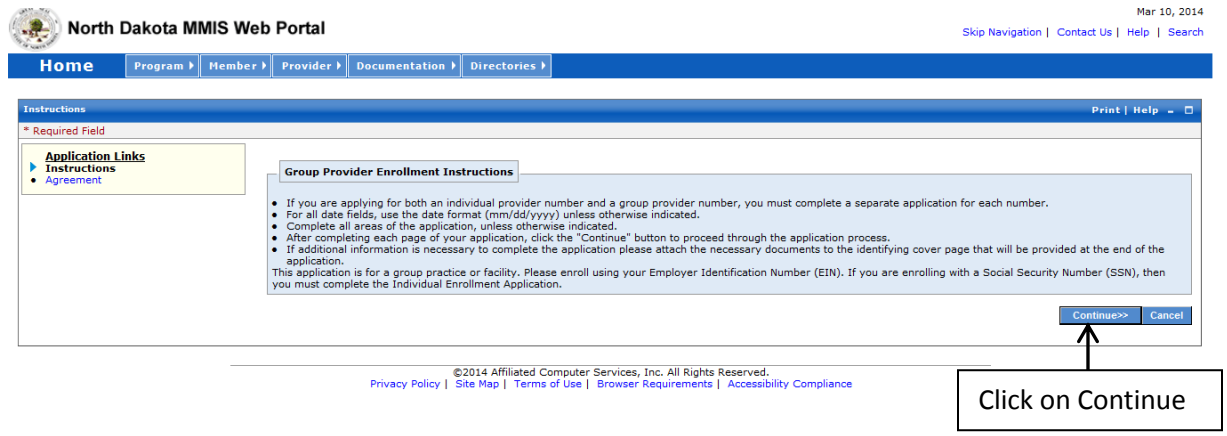


STEP 2: Click on **Provider Enrollment**

STEP 3: Your screen should appear like this: Click on **Group Provider Enrollment**



STEP 4: Click on **Continue**

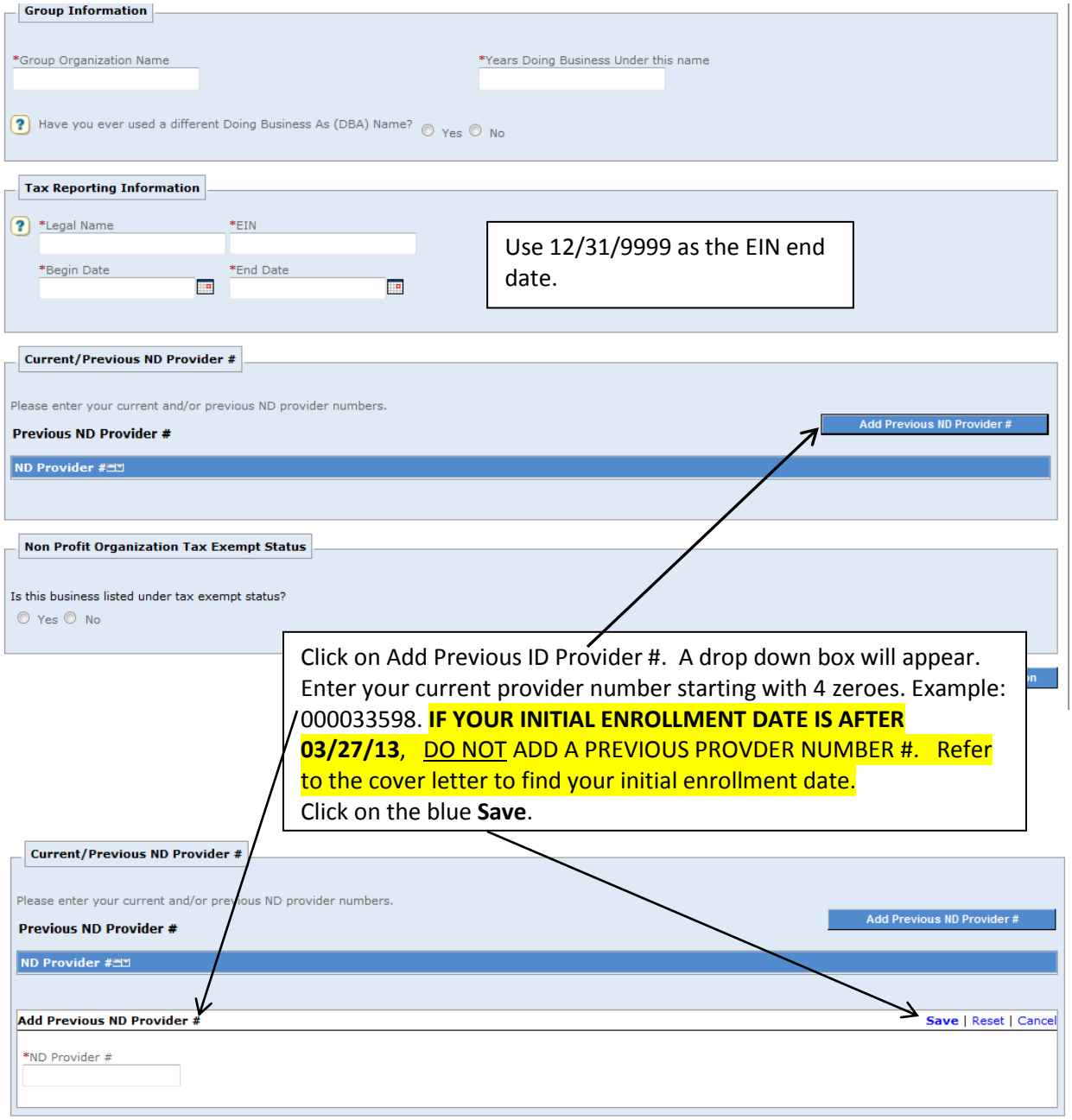


STEP 5: Click **Accept**

There is a **Help** area in the **left hand column** of the page. This provides an explanation of the information required and assistance in navigating the application.

Any field marked with a red asterisk is required.

STEP 6: Enter the information as prompted on the screen

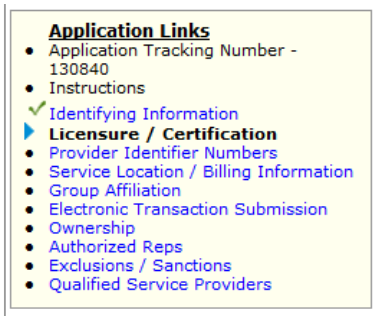


When entire page is completed, click the blue **Save** box on bottom of page.

You should see the following message at the top of the page:
The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ###### for future access to the Enrollment Application.

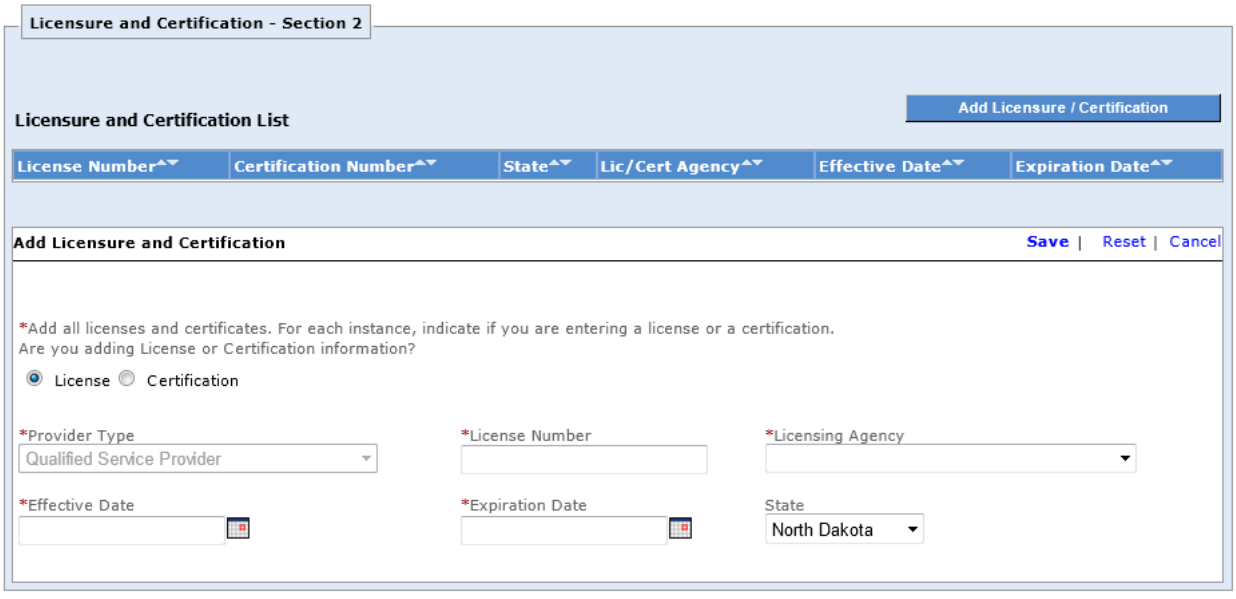
Write the tracking number down: TRACKING NUMBER: __ __ __ __ __ __.

STEP 7: Click on **Licensure/Certification** in the left hand column **or** the **Continue** button at the bottom of the page.

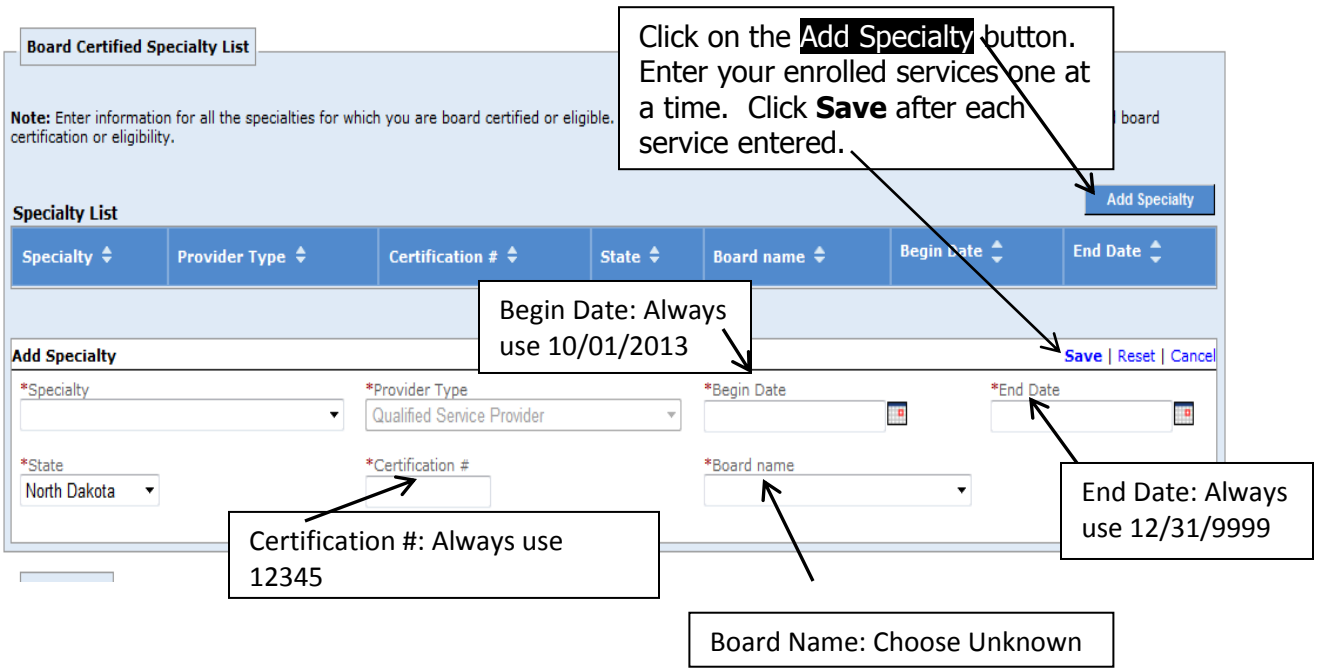


STEP 8: Chose **Qualified Service Provider** as the **Provider Type**.

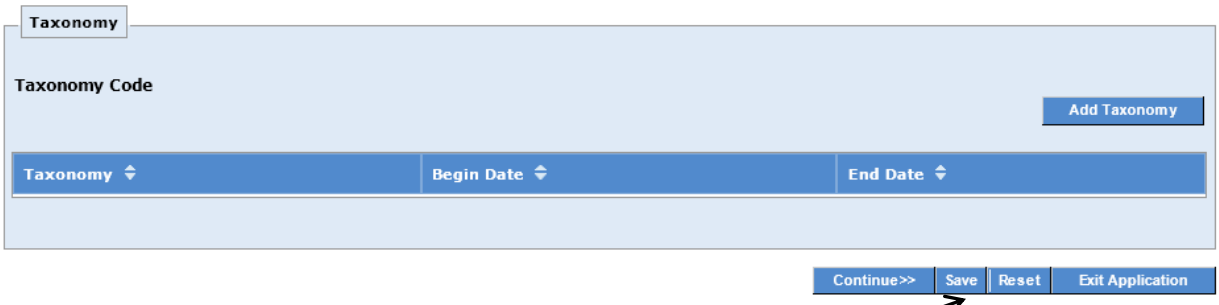
STEP 9: If your agency has licensures/certifications click on the Add Licensure /Certification button You will then see a drop down box. Fill in the boxes, then click on the blue highlighted **Save**. If you have more than one license click on the Add Licensure/Certification button again. Repeat as needed to add more.



STEP 10: Add your enrolled services one at a time following the directions below. A service is named a 'specialty' in this MMIS application.



STEP 11: Skip the Taxonomy section at bottom of this page.

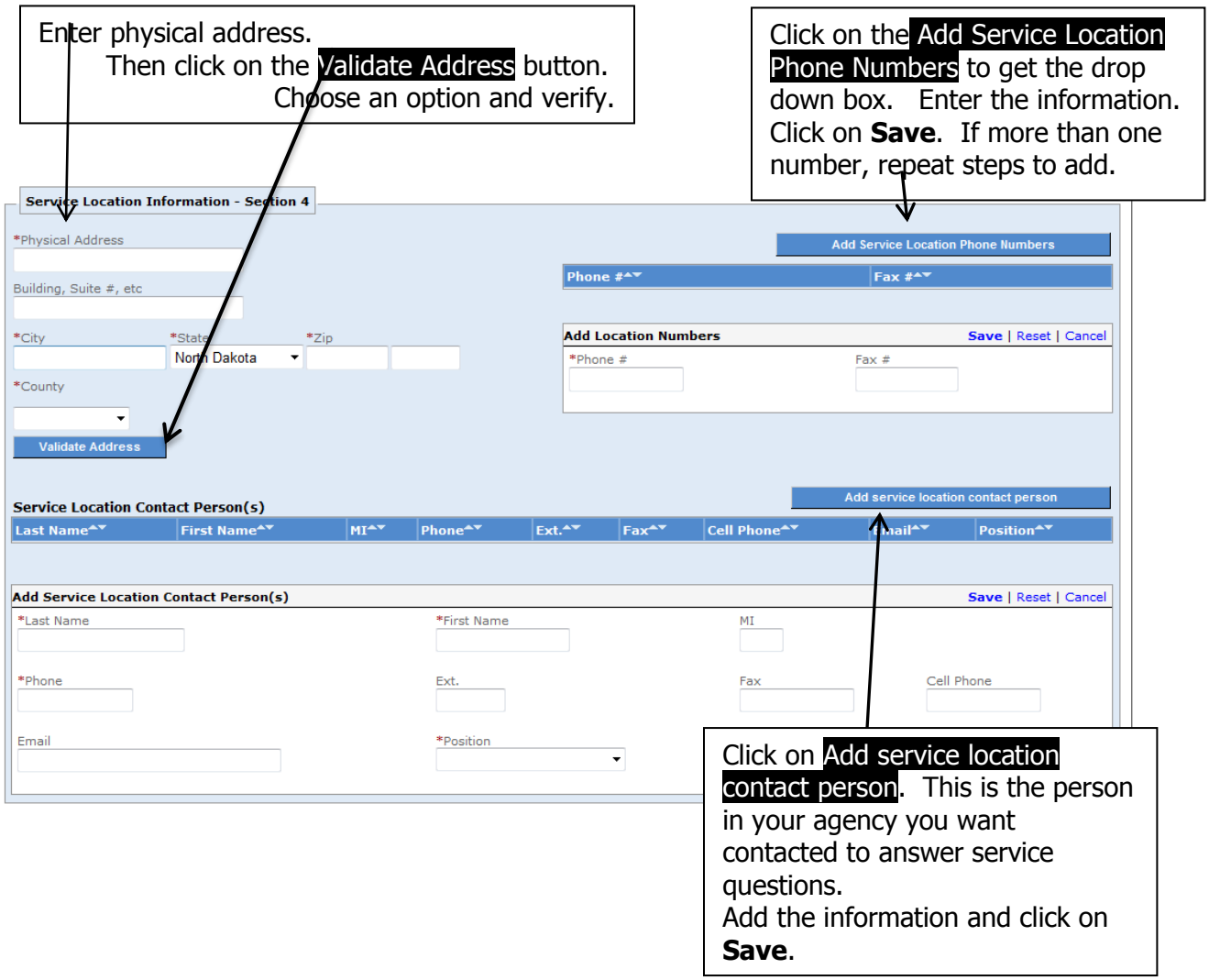


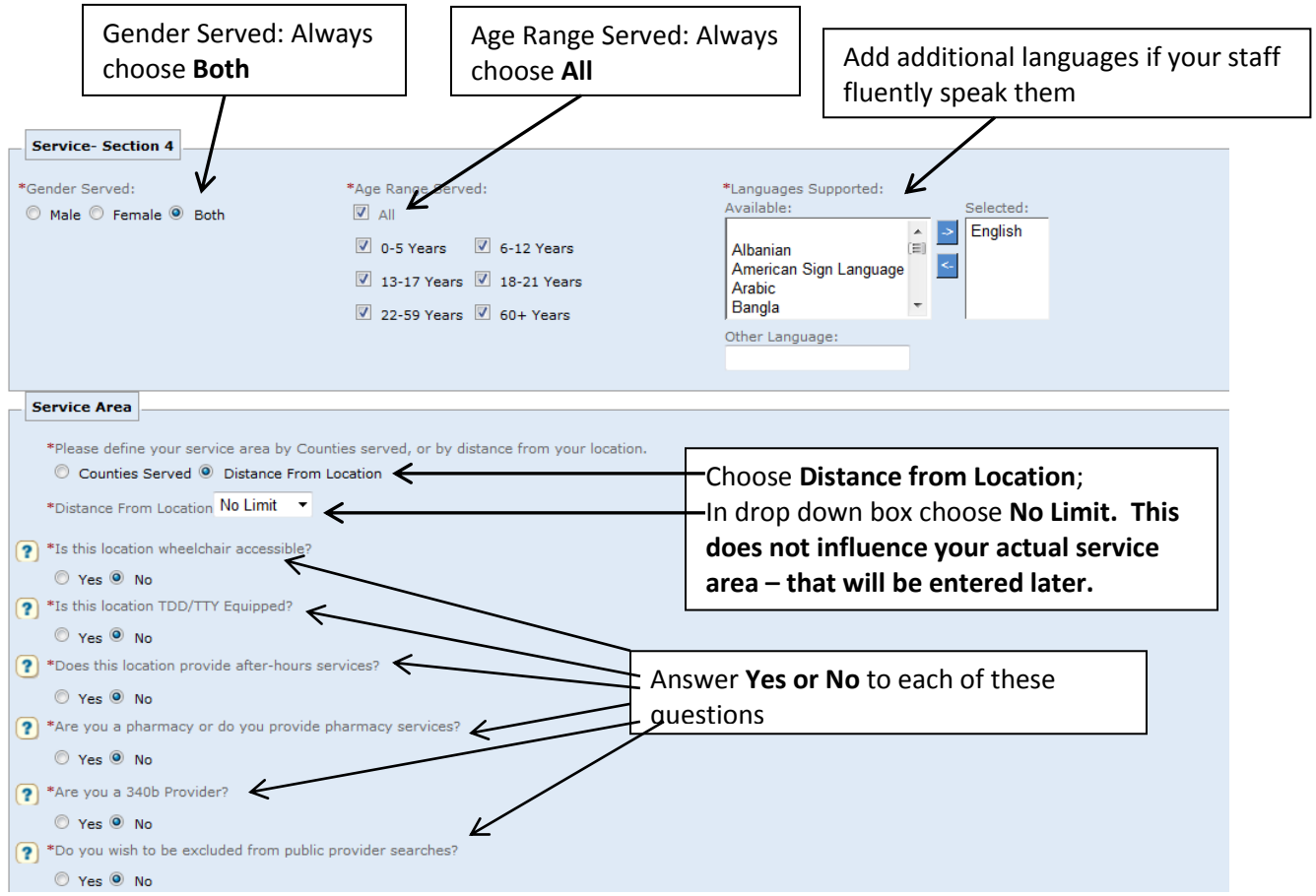
Click on the blue **Save** box at the bottom of the page.

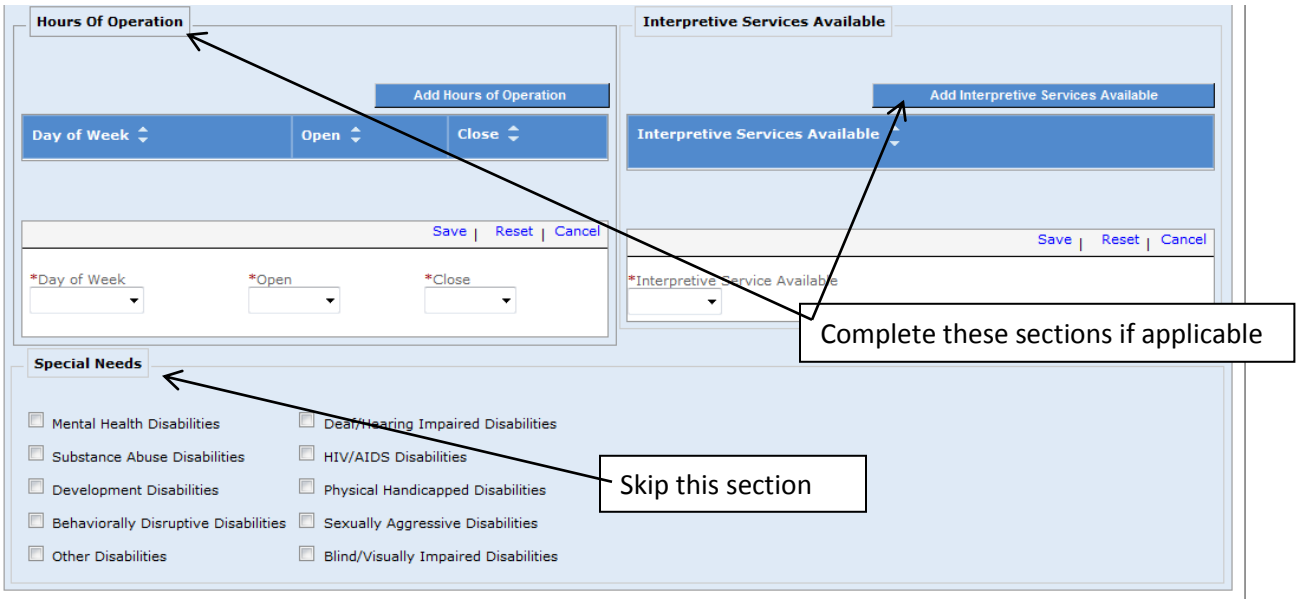
You should see the following message at the top of the page:
The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ###### for future access to the Enrollment Application.

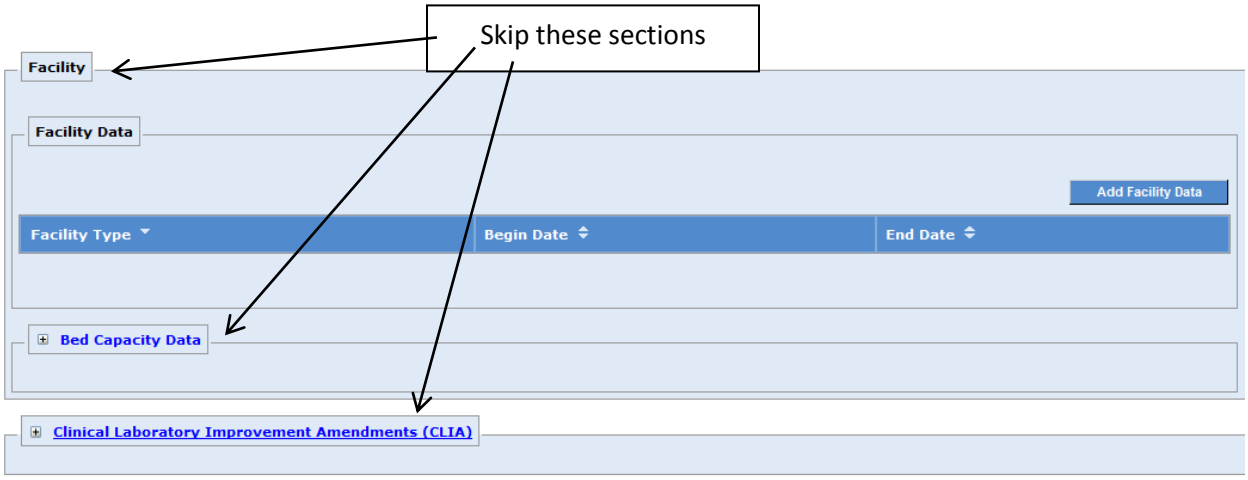
STEP 12: Skip the **Provider Identifier Numbers Section 3** page.

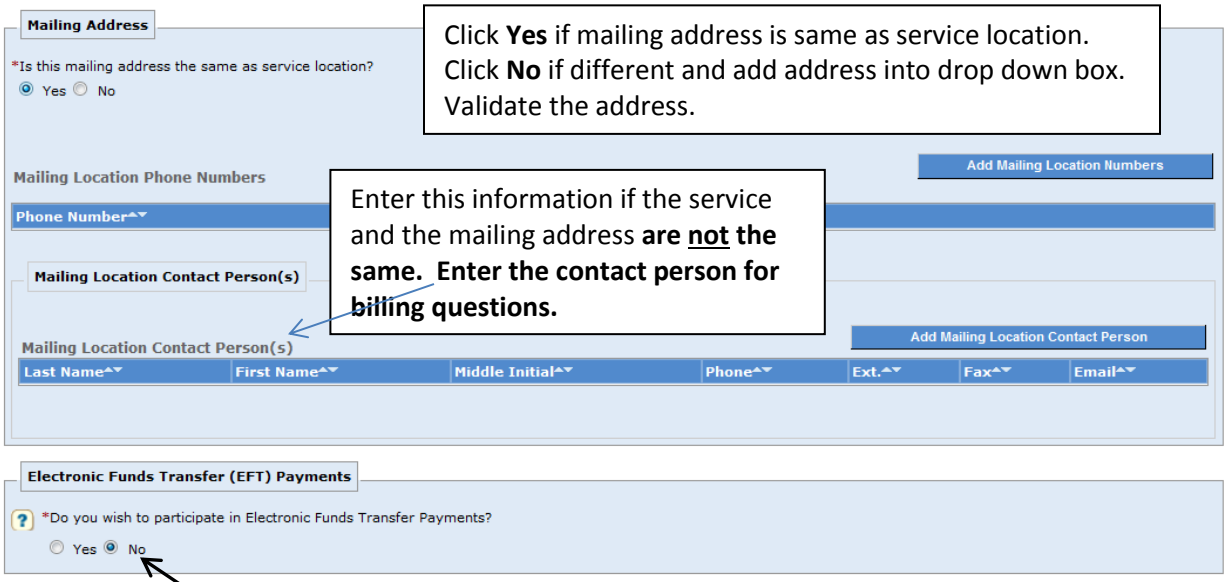
STEP 13: Go to the **Service Location/Billing Information Section 4** page by either clicking in the **Application Links** section (top left hand column) or the **Continue button** on the bottom of the page. Enter the information as directed below:



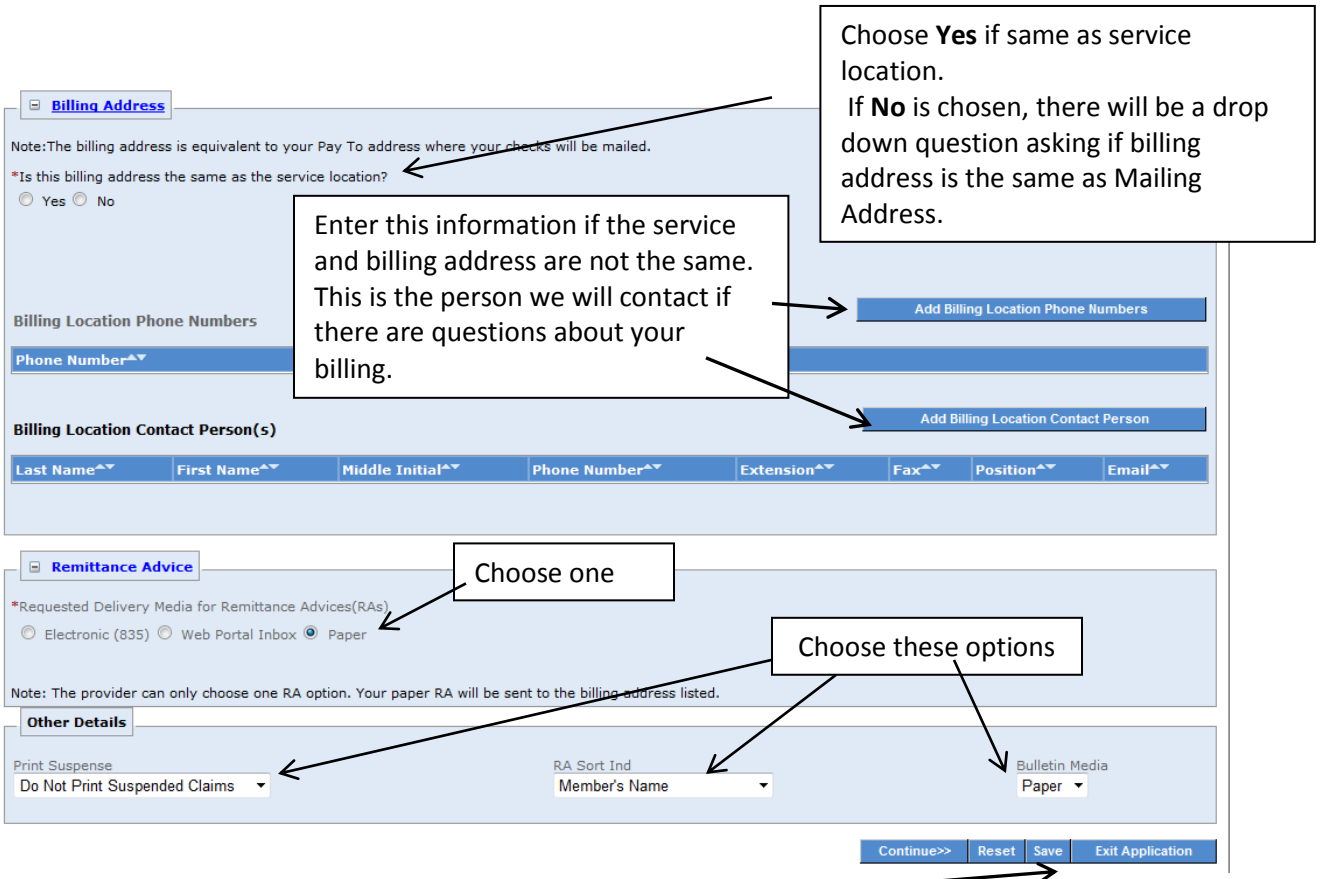

Gender Served: Always choose **Both**
Age Range Served: Always choose **All**
Add additional languages if your staff fluently speak them
Service- Section 4
*Gender Served:
Male Female Both
*Age Range Served:
All
0-5 Years 6-12 Years
13-17 Years 18-21 Years
22-59 Years 60+ Years
*Languages Supported:
Available:
Albanian
American Sign Language
Arabic
Bangla
Selected:
English
Other Language:
Service Area
*Please define your service area by Counties served, or by distance from your location.
Counties Served Distance From Location
*Distance From Location No Limit
Choose **Distance from Location**;
In drop down box choose **No Limit. This does not influence your actual service area – that will be entered later.**
*Is this location wheelchair accessible?
Yes No
*Is this location TDD/TTY Equipped?
Yes No
*Does this location provide after-hours services?
Yes No
*Are you a pharmacy or do you provide pharmacy services?
Yes No
*Are you a 340b Provider?
Yes No
*Do you wish to be excluded from public provider searches?
Yes No
Answer **Yes or No** to each of these questions


Hours Of Operation
Add Hours of Operation
Day of Week
Open
Close
Save | Reset | Cancel
*Day of Week
*Open
*Close
Interpretive Services Available
Add Interpretive Services Available
Interpretive Services Available
Save | Reset | Cancel
*Interpretive Service Available
Complete these sections if applicable
Special Needs
Mental Health Disabilities
Substance Abuse Disabilities
Development Disabilities
Behaviorally Disruptive Disabilities
Other Disabilities
Deaf/Hearing Impaired Disabilities
HIV/AIDS Disabilities
Physical Handicapped Disabilities
Sexually Aggressive Disabilities
Blind/Visually Impaired Disabilities
Skip this section





Check **No**.
This information will be entered by HCBS Medical Services staff from the enrollment forms currently on file.

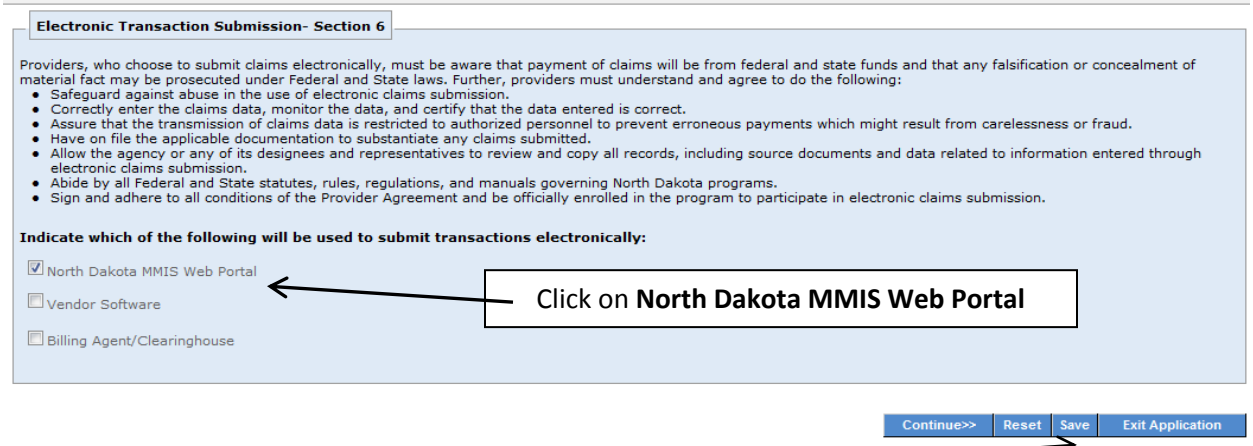


Click on the blue **Save** button at the bottom of the page.

You should see the following message at the top of the page:
The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ###### for future access to the Enrollment Application.

STEP 14: Skip the **Group Affiliation – Section 5** page by clicking **continue** or using the application links in the left hand column.

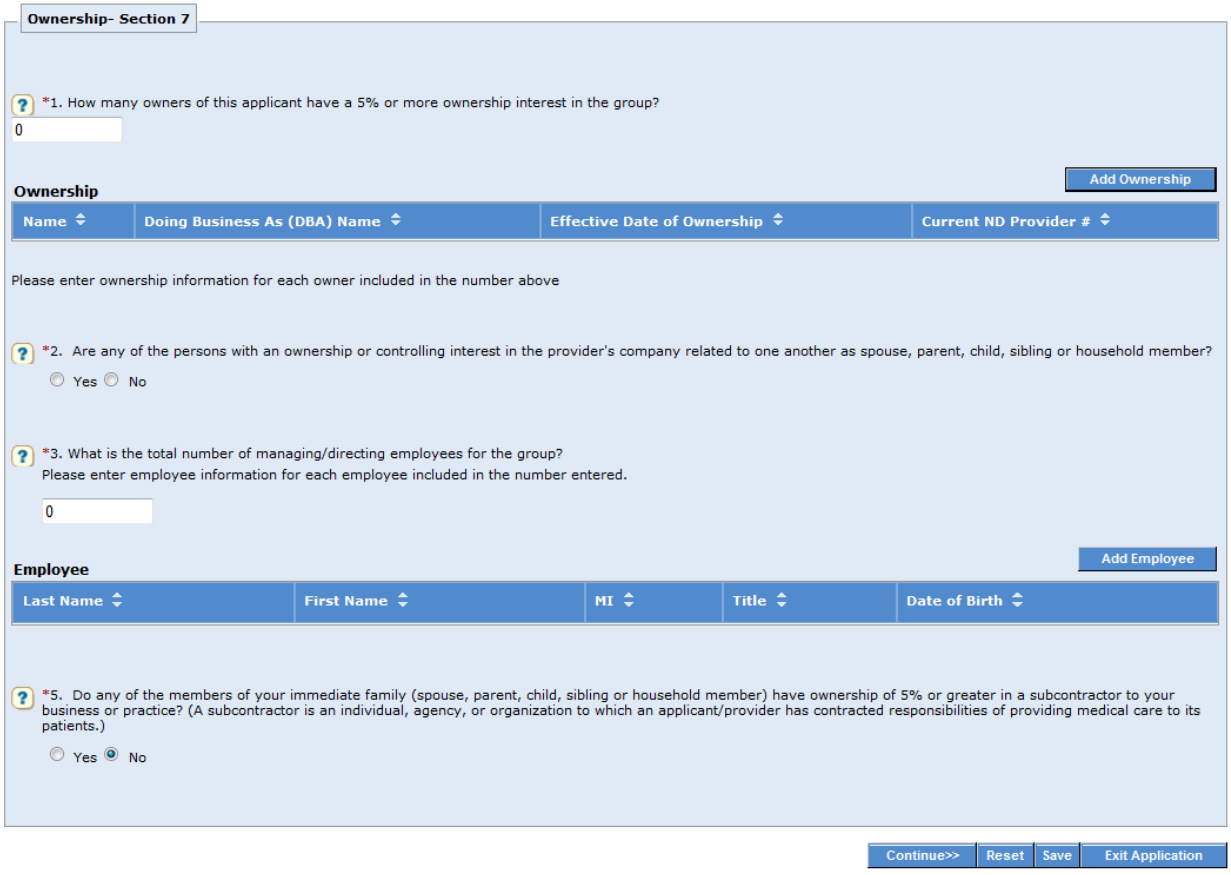
STEP 15: Go to the **Electronic Transaction Submission** page by clicking **continue** or using the application links in the left hand column.



Click **Save** at the bottom of the page.

You should see the following message at the top of the page:
The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ###### for future access to the Enrollment Application.

STEP 16: Click the **Continue** button or use the Application Links on the left hand side of the page to go to Ownership – Section 7 page.



See the Help section in the left hand column. Answer the questions. Use your current SFN 1168 to find the information.
Please note that the SFN 1168 Ownership & Controlling Interest form on file with Medical Services will be used as the official record as this ownership section does not contain all current CMS requirements.

Click on the blue **Save** button at the bottom of the page.

You should see the following message at the top of the page:
The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ###### for future access to the Enrollment Application.

Click **Continue**.

STEP 17: Skip the **Authorized Representatives** page.

STEP 18: Continue to the **Exclusion/Sanctions – Section 7** page, Answer all questions.

Exclusion / Sanction- Section 7

*1.Are any of the named owners related to owners of the subcontractor as spouse, parent, child, sibling or household member?

Yes No

*2.Is the group chain affiliated?

Yes No

*3.Is the group operated by a management company or leased in whole or part by another organization?

Yes No

*4.Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5% or more in the group that have been convicted of a criminal offense related to involvement of such individuals, or organization in any of the programs established by Medicare, Medicaid, and State Health Insurance Programs?

Yes No

*5.Are there any directors, officers, agents, or managing employees of the group that have ever been convicted of a criminal offense related to their involvement in such programs established by Medicare, Medicaid, and State Health Insurance Program?

Yes No

*6.Has any family or household member or any person who has ownership or controlling interest in the group, ever been convicted, assessed, or excluded from State or Federal programs due to fraud, obstruction of an investigation or a controlled substance violation?

Yes No

*7.Does the applicant under any name or business identity, have any outstanding overpayments with any state or federal program?

Yes No

*8.Has the applicant ever been convicted of a felony under Federal or State Law?

Yes No

If you have ever had any of the following adverse legal actions imposed or are pending by any federal or state agency or program, check the appropriate box and indicate the date when the adverse legal action was imposed.

Important: Attach copy of adverse legal action notification(s).

*9. Administrative Sanction(s)?

Yes No

*10. Professional Board Disciplinary Action(s)?

Yes No

*11. Program Exclusions?

Yes No

*12. Suspension of Payments?

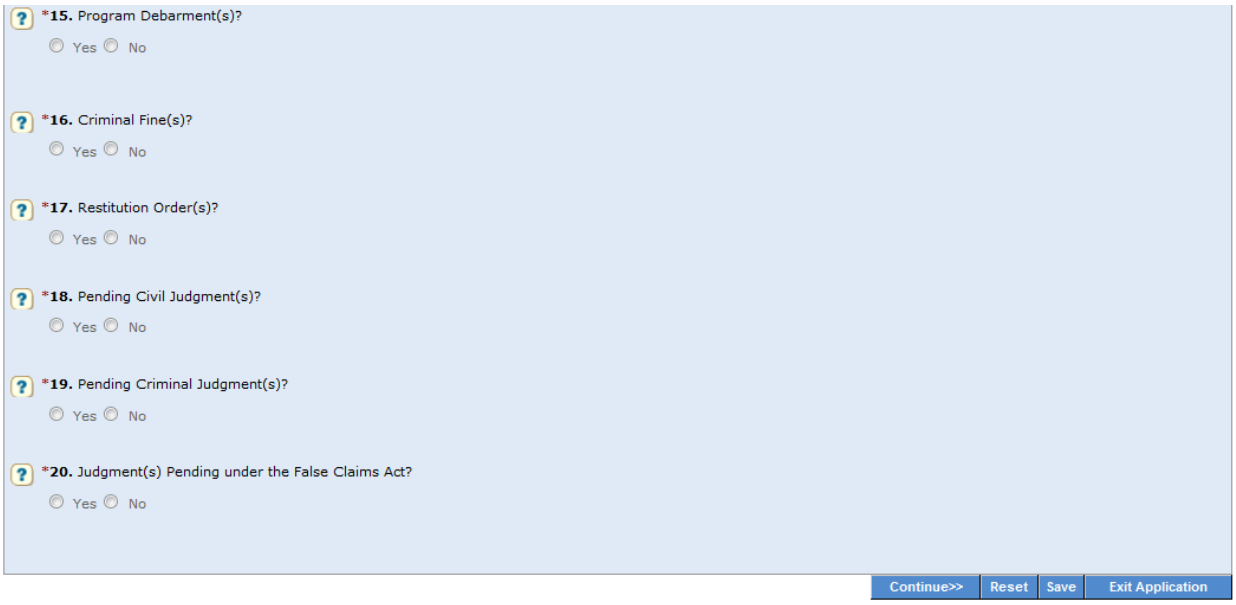
Yes No

*13. Civil Monetary Penalty(s)?

Yes No

*14. Assessment(s)?

Yes No

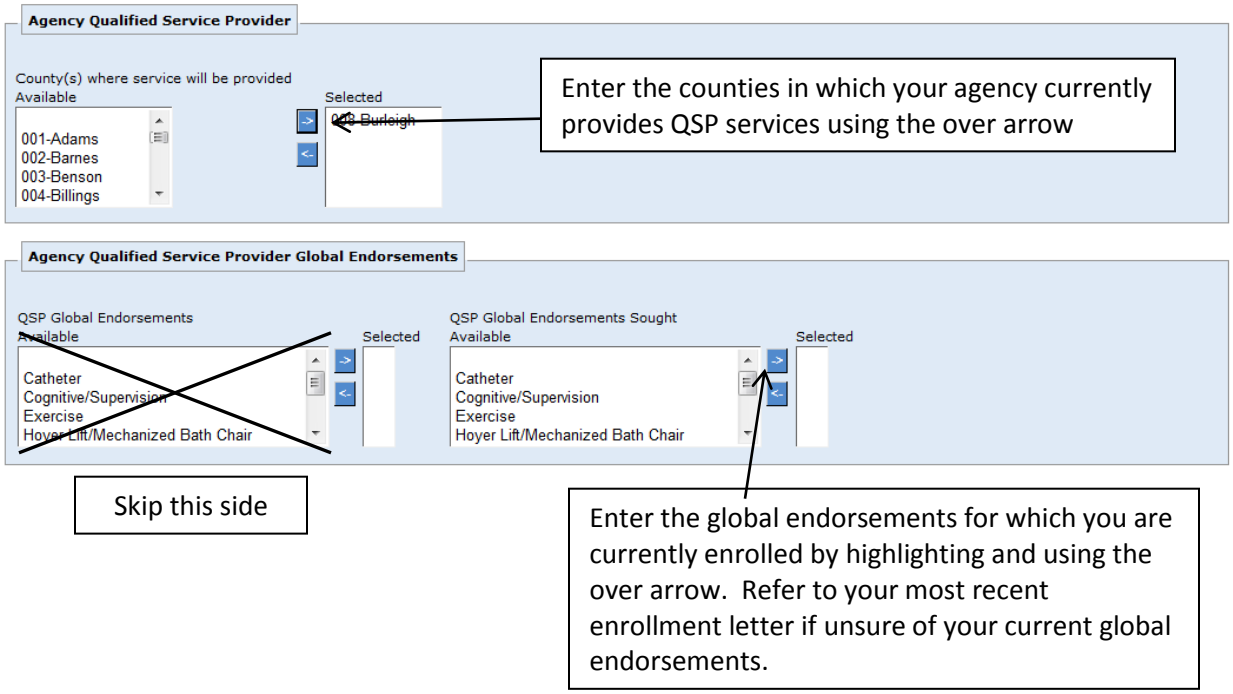


Click on the blue **Save** button at the bottom of the page.

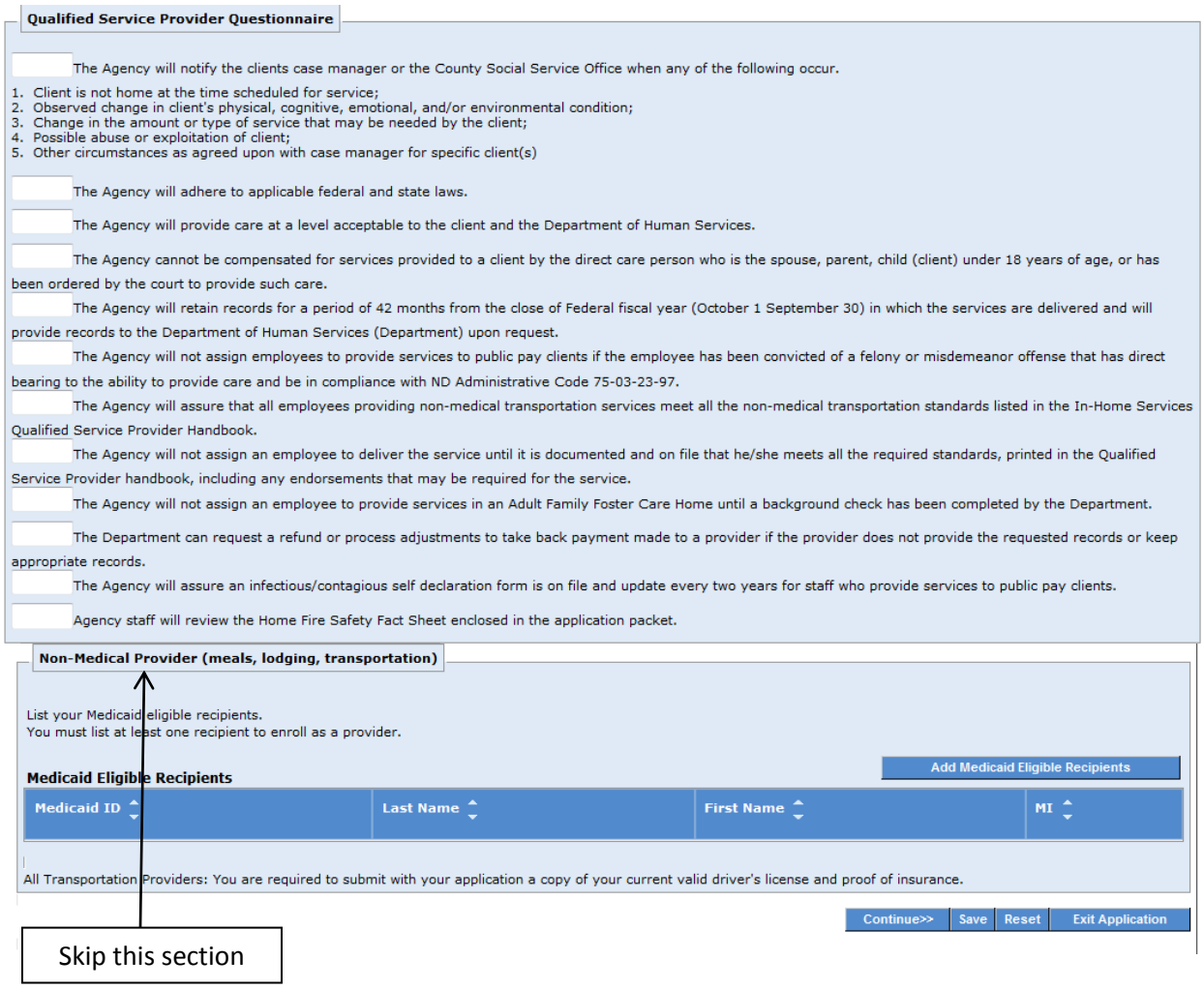
You should see the following message at the top of the page:
The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ###### for future access to the Enrollment Application.

Click **Continue**.

STEP 19: This will take you to the **Agency Qualified Service Provider** page.



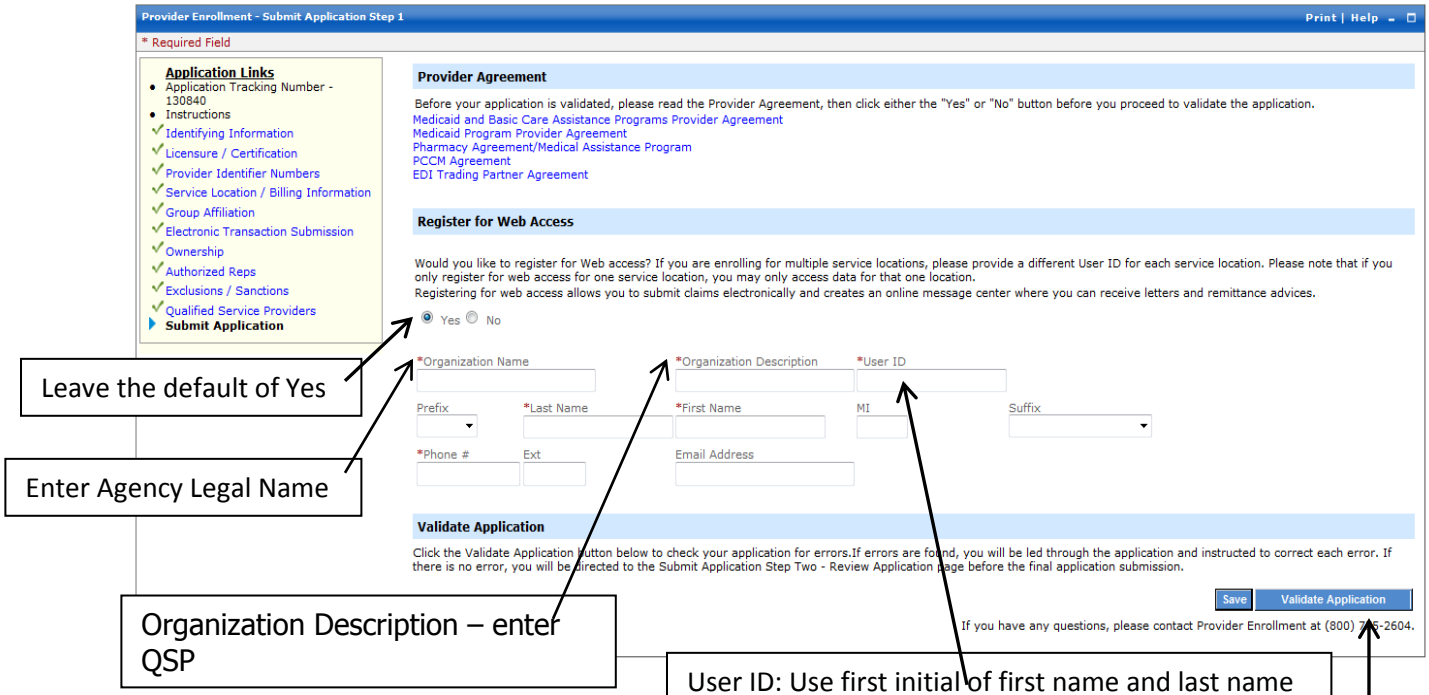
Each of the statements below must be initialed with the initials of the person authorized to sign the application.



Click on the blue **Save** button at the bottom of the page.

You should see the following message at the top of the page:
The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ###### for future access to the Enrollment Application.

STEP 20: Click on **Continue** to go to **Submit Application** page – Read the **Provider Agreement**.



Leave the default of Yes

Enter Agency Legal Name

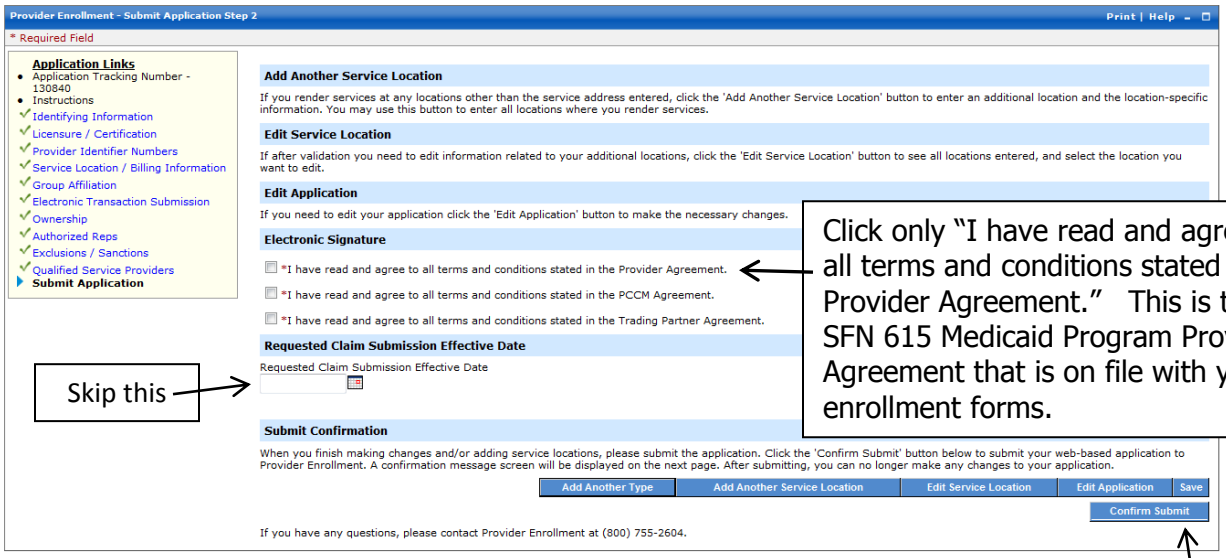
Organization Description – enter QSP

User ID: Use first initial of first name and last name of the person who will do the billing. Click **Save** – if not accepted choose one of the suggestions listed in red. Click **Save** again. Write down the User ID along with the Application Tracking Number.

Click on **Validate Application**

User ID:_____

STEP 21: Follow the directions below:



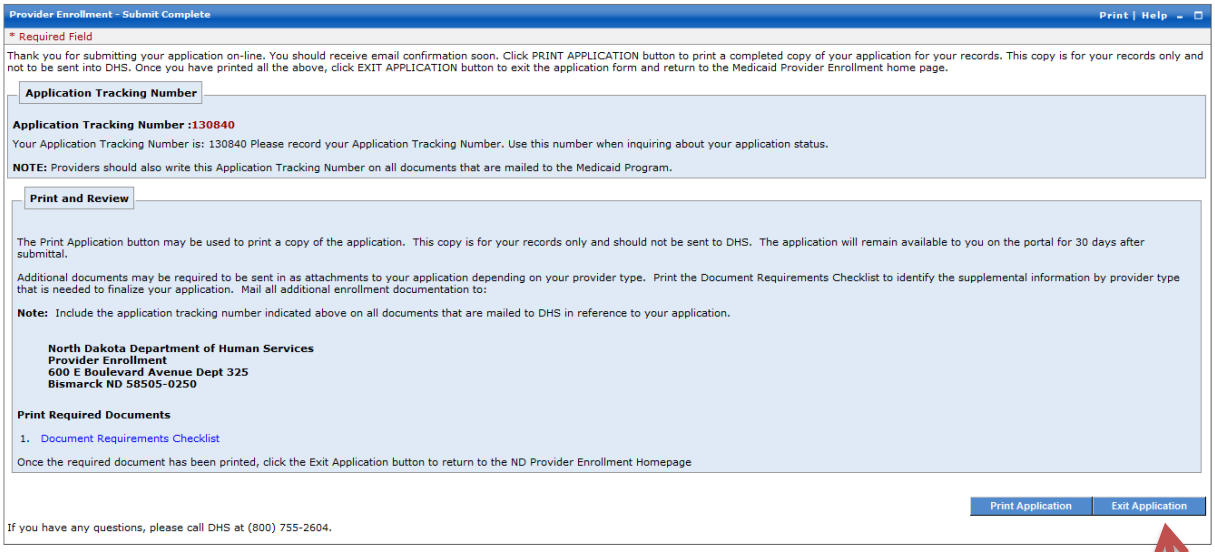
Skip this

Click only "I have read and agree to all terms and conditions stated in the Provider Agreement." This is the SFN 615 Medicaid Program Provider Agreement that is on file with your enrollment forms.

Click on the blue **Save** button at the bottom of the page.
You should see the following message at the top of the page:
The Provider Enrollment details have been saved successfully. Please note your Application Tracking Number ###### for future access to the Enrollment Application.

Then click on **Confirm Submit**.

STEP 22: You will be taken to the screen below:



The Documents Requirements Checklist does not apply.
You should not send any additional documentation. Remember we have your current written QSP Agency enrollment forms and documents on file.

Print the application for your file. Make sure you have written down the Application Tracking Number for future reference.

Click on **Exit Application**.

- Remember - your agency must be entered into the North Dakota MMIS Web Portal **no later than June 1, 2014** for your claims/payments to pay when the new billing system starts.

- Medical Services will send you a written notice that the application has been approved. That will be the verification that you are enrolled into the new MMIS system.